



Complete Summary

GUIDELINE TITLE

American Association of Clinical Endocrinologists medical guidelines for clinical practice for the evaluation and treatment of male sexual dysfunction: a couple's problem--2003 update.

BIBLIOGRAPHIC SOURCE(S)

AACE Male Sexual Dysfunction Task Force. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the evaluation and treatment of male sexual dysfunction: a couple's problem--2003 update. Endocr Pract 2003 Jan-Feb;9(1):77-95. [26 references]

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SCOPE

DISEASE/CONDITION(S)

Male sexual dysfunction

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Endocrinology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present a framework for the evaluation, treatment, and follow-up of the patient and couple who present with sexual dysfunction

TARGET POPULATION

Men with sexual dysfunction

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation

1. Initial assessment of relevant medical, psychological, and hormonal factors of the male patient and his partner
2. Sexual history, medical history, and physical examination
3. Diagnostic tests (i.e., blood chemistry, vascular assessment, sensory studies, nocturnal penile tumescence and rigidity testing)

Treatment/Management

1. Psychological therapy, referral to sex therapist
2. Medical treatment, if applicable: plasma glucose control, hypertension control, tobacco use cessation, hyperlipidemia therapy, alcohol intake decrease or discontinuation, and illicit drug discontinuation
3. Changing or stopping offending medications
4. Testosterone therapy: injection, scrotal/nonscrotal patches
5. Major nonspecific treatment options: yohimbine tablets, vacuum pump devices, venous constriction rings, corpora cavernosal injections of various chemicals, intraurethral drug suppositories, intrapenile arterial or venous surgical procedures, penile implants, or orally administered phosphodiesterase inhibitors (sildenafil)
6. Urology consult for surgical options

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Searches of Index Medicus and Pub Med were performed. Articles retrieved were supplemented by material from the personal libraries of the committee members.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Meta-Analyses and Reviews > Randomized controlled studies > Observational studies > Expert opinions (in order of most weight)

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Twelve physicians are acknowledged as reviewers in the guideline document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

System of Care for Male Sexual Dysfunction

Step 1: Accurate history (preferably with the couple)

- A. Make sure concerns are not just aging-related changes
- B. Inquire about relationship problems
- C. Question about performance anxiety

Action: Reassure if A
Send to sex therapist if B or C
Do nocturnal penile test if uncertain.

- D. Outline medical risk factors and medications

Action: Change or discontinue medications
Stop any substance abuse

Step 2: General examination

- A. Blood pressure
- B. Breasts for gynecomastia
- C. Secondary sex characteristics
- D. Peripheral circulation
- E. Genital examination
Especially for penile fibrosis, testicular atrophy, bulbocavernosal reflex
- F. Rectal examination
Especially assess prostate

Action: Follow-up on abnormal findings--that is, cardiovascular findings, suspected endocrine diseases, or abnormal prostate

Step 3: Laboratory tests

- A. Plasma glucose
- B. Prolactin
- C. Free testosterone
- D. Luteinizing hormone and follicle-stimulating hormone if testicular atrophy suspected
- E. Thyroid-stimulating hormone or free thyroxine (or both) if hypothyroidism is suspected
- F. Other tests, depending on history and physical examination

Step 4: Treatments

A. Related to risk factors

Action: Diagnose diabetes

Stop any substance abuse

Change medications

Treat abnormal hormones (testosterone or prolactin)

A 3-month testosterone trial, if indicated

Nocturnal penile tumescence and rigidity testing if risk factors changed and nonresponse may be due to psychologic factors

B. If good erections but early detumescence--venous constriction rings

C. Nonspecific treatments:

Trial sildenafil

Trial yohimbine

Other orally administered drugs, phentolamine, apomorphine (when approved)

Apomorphine (sublingually)

Vacuum pump

Medicated urethral system for erection (intraurethral prostaglandin pellet)

Penile injections

- Papaverine and phentolamine
- Papaverine, phentolamine, alprostadil
- Alprostadil alone

Penile implants (as last resort)

D. Surgical referrals (urologist)

Severe Peyronie's disease

Penile injections (if not done by endocrinologist)

Penile implant

Selected cases of arterial damage or venous ligation

CLINICAL ALGORITHM(S)

An algorithm for office evaluation of erectile dysfunction is provided in the original guideline document.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate recognition and management of disorders of sexual desire, orgasm, and ejaculation through an organized system of care for the couple. The outcome can be cost-effective improvement.

POTENTIAL HARMS

Sildenafil

Side effects are generally mild and tolerable: headaches, hot flashes, heartburn, diarrhea, myalgias, hypotension, and dizziness. The drug may inhibit phosphodiesterase type 6 in the eye, with resultant difficulty in discriminating blue from green, bluish tones in vision, or difficulty seeing in dim light. Whether any adverse effect occurs in diabetic retinopathy or other eye diseases is yet to be determined.

Yohimbine tablets

Major side effects are uncommon, but minor symptoms, including headaches, dizziness, insomnia, and anxiety, may occur in 25% of cases during the first week of treatment. Patients who have blood pressure that is difficult to control might notice a pressure increase.

Alprostadil

The major side effects, which occur in 3 to 10% of patients, are penile pain, cavernosal scarring, or priapism.

Penile Implants

Treatment failures attributable to infection, extrusion, or mechanical failure, especially in patients with diabetes, previously were as high as 36%, but better equipment and techniques have reduced these complications.

CONTRAINDICATIONS

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Sildenafil is contraindicated in patients taking nitrates in any form, inasmuch as severe hypotension and resultant syncope have occurred as well as cardiogenic shock and some deaths.

QUALIFYING STATEMENTS

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These guidelines are intended as a general outline but not meant to dictate or delineate any specific treatments for patients. The area of treatment of sexual dysfunction, and especially erectile dysfunction, is a relatively new discipline. Basic physiologic and pathologic data have recently been elucidated, but many controversial issues remain. Whenever possible, the guideline developers have

presented a majority opinion, while describing various other possibilities. New advances in technology and treatment will keep this field dynamic and in a state of evolution. Thus, modification of ideas will be necessary as new data become available.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

AACE Male Sexual Dysfunction Task Force. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the evaluation and treatment of male sexual dysfunction: a couple's problem--2003 update. *Endocr Pract* 2003 Jan-Feb;9(1):77-95. [26 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2003)

GUIDELINE DEVELOPER(S)

American Association of Clinical Endocrinologists - Medical Specialty Society
American College of Endocrinology - Medical Specialty Society

SOURCE(S) OF FUNDING

American Association of Clinical Endocrinologists (AACE)

GUIDELINE COMMITTEE

American Association of Clinical Endocrinologists (AACE) Male Sexual Dysfunction Task Force

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Association of Clinical Endocrinologists (AACE), American College of Endocrinology. AACE clinical practice guidelines for the evaluation and treatment of male sexual dysfunction. Endocr Pract 1998 Jul-Aug; 4(4): 219-35.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [American Association of Clinical Endocrinologists \(AACE\) Web site](#).

Print copies: Available from AACE, 1000 Riverside Ave., Suite 205, Jacksonville, FL 32204.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on October 1, 1998. The information was verified by the guideline developer on December 15, 1998. This summary was updated by ECRI on June 25, 2003. The updated information was verified by the guideline developer on July 21, 2003.

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Date Modified: 11/8/2004

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